

Debra Lee Carr, LPC Counseling and Consulting, LLC

Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form **completely** and bring with you to your first session. **Items marked with an * must be completed.**

*Legal Name: _____
(Last) (First) (Middle Initial) (Maiden)

*Birth Date: ____/____/____ Age: ____ *Gender: M F *Social Security #: ____-____-____

Preferred Name: _____

*Parent/guardian Name
(if under 18 years): _____
(Last) (First) (Middle Initial)

*Marital Status: Never Married Married Divorced Widowed Separated Domestic Partnership

*Address: _____
(Street and Number) (PO Box) (City) (State) (Zip)

*Home Phone: (____) ____-____ May we leave a message? Yes No

*Cell Phone: (____) ____-____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation: _____ Employer: _____ Are you a student? Y N

Any other family members/ friends seen here: _____

Please list any children/age: _____

Referred by (if any): _____

*Primary Care Doctor: _____ PCP Phone: (____) ____-____

***Emergency Contact:** In case of an Emergency, we will need to contact a local friend or relative.
Please provide the name, relationship and a phone number for this emergency contact.

(Name) (Relationship to client) (Phone Number)

***Primary Insurance Information (PLEASE PRESENT YOUR INSURANCE CARD TO RECEPTIONIST. A COPY WILL BE KEPT IN YOUR FILE.)**

Name of Insurance: _____ Subscriber's Legal Name: _____

Subscriber's Social Security #: _____ Birth Date: ____/____/____ Gender: M F

Subscriber's ID #: _____ Group #: _____

Client's Relationship to Subscriber: Self Spouse Child Other

Secondary Insurance Information (if applicable)

Name of Insurance: _____ Subscriber's Legal Name: _____

Subscriber's Social Security #: _____ Birth Date: ____/____/____ Gender: M F

Subscriber's ID #: _____ Group #: _____

Client's Relationship to Subscriber: Self Spouse Child Other

Please initial each of the following statements, sign and date at the bottom:

***COUNSELING SERVICES APPOINTMENT POLICY**

_____ All clients are expected to attend appointments as scheduled. It is recognized that occasionally circumstances occur that require missing an appointment. It is the client's responsibility to call to reschedule counseling sessions. Clients will be charged a \$60.00 fee for any missed appointment and if they fail to cancel an appointment at least one business day in advance (i.e., cancel Monday appointments by 5 p.m. the preceding Friday; and Tuesday through Friday appointments must be canceled 24 hours in advance).

***CONFIDENTIALITY**

_____ NO information about your counseling will be released to anyone without your prior WRITTEN authorization, except in the following situations:

1. When there is risk of imminent harm to yourself or another person, counselor is legally and ethically bound to do whatever is necessary to protect life.
2. When a court of law orders information to be released, counselor is legally bound to comply.
3. When there is reasonable cause to suspect that a child, elderly person, or mentally incompetent person is being abused, neglected, or exploited, counselor is legally bound to report such abuse.
4. If you are involved in a medical emergency, information may be given to medical personnel.
5. If you participate in group counseling, as a member of the group you will be expected to commit to maintaining the confidentiality of that group, including keeping secret the identities of the other members of the group.

Counselors retain the privilege to consult with peers about clients for treatment and/or training purposes, but no identifying information will be used in order to protect client's confidentiality. I understand the limits to confidentiality stated above, and I accept them as part of the conditions of participating in counseling.

***ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

_____ I acknowledge that I am aware I can request a copy of the *Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing service to me.

***FINANCIAL POLICY**

_____ 1. **INSURANCE:** Counseling services are provided directly to the client and not to an insurance company. Thus, you are expected to pay all co-pay and deductible amounts at time of service. I understand that it is my responsibility to check with my insurance representative to make sure that this service is covered by my policy. I also understand this is not a guarantee of coverage and I will be responsible for any balance my insurance company denies or deems not medically necessary.

_____ 2. **SPECIAL NEEDS:** Special needs are understood by this office. It may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation is necessary for you, please bring this to our attention as soon as possible.

***I WOULD LIKE TO REQUEST SERVICES FOR MYSELF AND CONSENT TO PARTICIPATE IN COUNSELING**

_____ Clients will be treated with respect and dignity, especially with regard to age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, or socioeconomic status. I understand that participation in counseling is strictly voluntary. I have asked for any needed clarification of the conditions mentioned above, I am satisfied with the explanations, and I agree to abide by these conditions. I consent to participate in counseling and I understand that I may withdraw this consent at any time.

* _____
(Client Signature)

_____ _____
(Witness Signature)

* _____
(Date)

*Client Questionnaire

Your cooperation in completing this questionnaire will help us serve you better

Please answer each item carefully.

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Age _____ **Gender** Male Female Female
Employed Yes No
If Yes, # hours/week _____
Place of Employment? _____
Live With Roommate Significant Other Alone Family

Ethnicity Asian/Asian American Black/African American Latino/Hispanic American
 Native American White/Non-Hispanic American Other American
 Multi-racial American International Student: What country? _____

Sexual Orientation Heterosexual Lesbian Gay Man Bisexual Transgender

Relationship Status Single Married Widowed Partnered Divorced In committed dating relationship Separated

Please list anyone who may attend sessions with you and their age: _____

Religious affiliation, if any (optional) _____

Have you previously used our services? Yes No When? _____

Who referred you? _____

May we call that person to let them know you came to see us? Yes No

Have you previously received any psychological, psychiatric, or counseling services?
 Yes No If yes, please describe: _____

Do you have any chronic medical conditions, including pain or any disabilities?
 Yes No If yes, please describe: _____

Please list all current medications: _____

Please briefly describe what you see as the problem for which you seek counseling at this time:

Please check all of the following items which are concerns at this time, and circle the most important.

- | | | | |
|-------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Discrimination | <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Romantic relationship |
| <input type="checkbox"/> Abuse- physical/sexual | <input type="checkbox"/> Divorce, separation | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Self-injury, mutilation |
| <input type="checkbox"/> Abuse- emotional/neglect | <input type="checkbox"/> Eating problems/ disorder | <input type="checkbox"/> Loss of pleasure in activities | <input type="checkbox"/> Self-neglect, poor self-care |
| <input type="checkbox"/> Academic functioning | <input type="checkbox"/> Emptiness | <input type="checkbox"/> Loneliness, no friends | <input type="checkbox"/> Sexual assault |
| <input type="checkbox"/> Aggression or anger | <input type="checkbox"/> Family relationships | <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Sexual concerns |
| <input type="checkbox"/> Alcohol and/ or drug use | <input type="checkbox"/> Fatigue, tiredness | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Sexual harassment |
| <input type="checkbox"/> Anger, arguing | <input type="checkbox"/> Fearing Failure | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Sexual orientation |
| <input type="checkbox"/> Anxiety, panic attacks | <input type="checkbox"/> Fears, phobias | <input type="checkbox"/> Motivation, laziness | <input type="checkbox"/> Shame |
| <input type="checkbox"/> Appetite loss | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Attention, focus | <input type="checkbox"/> Friendships | <input type="checkbox"/> Over-responsible for others | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Body image | <input type="checkbox"/> Gambling | <input type="checkbox"/> Over-sensitive to rejection | <input type="checkbox"/> Social/dating problems |
| <input type="checkbox"/> Career concerns | <input type="checkbox"/> Grief | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Social isolation |
| <input type="checkbox"/> Childhood issues (yours) | <input type="checkbox"/> Guilt | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Smoking, tobacco use |
| <input type="checkbox"/> Children, parenting concerns | <input type="checkbox"/> Health, medical concern | <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Identity issues | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Decision making | <input type="checkbox"/> Impulsive, out of control | <input type="checkbox"/> Repeated troubling thoughts | <input type="checkbox"/> Thought disorganization |
| <input type="checkbox"/> Depression, sadness, crying | <input type="checkbox"/> Independence from parents | <input type="checkbox"/> Religious/spiritual concerns | <input type="checkbox"/> Worthless feelings |

| | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------------|--------------------------------------------|------------------------------------|-----------------------------------------------|---------------------------------|----------------------------------------------|-------------------------------------------|------------------------------------------|-------------------------------------------|
| <p>I use alcohol:</p> <input type="checkbox"/> Never <input type="checkbox"/> Less than once per week <input type="checkbox"/> About once per week <input type="checkbox"/> More than once per week <input type="checkbox"/> Most every day | <p>I use recreational drugs (pot, pills, inhalants, ect):</p> <input type="checkbox"/> Never <input type="checkbox"/> Less than once per week <input type="checkbox"/> About once per week <input type="checkbox"/> More than once per week <input type="checkbox"/> Most every day | <p>My use of alcohol &/or drugs has resulted in:</p> <table border="0"> <tr> <td><input type="checkbox"/> Traffic violations</td> <td><input type="checkbox"/> Fight with friends</td> </tr> <tr> <td><input type="checkbox"/> Academic problems</td> <td><input type="checkbox"/> Blackouts</td> </tr> <tr> <td><input type="checkbox"/> Ruined relationships</td> <td><input type="checkbox"/> Arrest</td> </tr> <tr> <td><input type="checkbox"/> Problems on the job</td> <td><input type="checkbox"/> Problems at home</td> </tr> <tr> <td><input type="checkbox"/> Health problems</td> <td><input type="checkbox"/> Marital problems</td> </tr> </table> | <input type="checkbox"/> Traffic violations | <input type="checkbox"/> Fight with friends | <input type="checkbox"/> Academic problems | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Ruined relationships | <input type="checkbox"/> Arrest | <input type="checkbox"/> Problems on the job | <input type="checkbox"/> Problems at home | <input type="checkbox"/> Health problems | <input type="checkbox"/> Marital problems |
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| <input type="checkbox"/> Ruined relationships | <input type="checkbox"/> Arrest | | | | | | | | | | | |
| <input type="checkbox"/> Problems on the job | <input type="checkbox"/> Problems at home | | | | | | | | | | | |
| <input type="checkbox"/> Health problems | <input type="checkbox"/> Marital problems | | | | | | | | | | | |

How much tobacco do you use daily? _____ **How interested are you in quitting (circle one)?** No interest Low Med High

| | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|------------------------------------------------------|----------------------------------------------------|-------------------------------------|------------------------------------------------------|--------------------------------------------|---------------------------------------------------|
| <p>I have tried to control my weight with:</p> <input type="checkbox"/> Vomiting <input type="checkbox"/> Laxatives <input type="checkbox"/> Not eating <input type="checkbox"/> Diet pills <input type="checkbox"/> Excessive exercise <input type="checkbox"/> Other _____ | <p>I have thought about or tried to:</p> <input type="checkbox"/> Harm myself - past <input type="checkbox"/> Harm myself - present <input type="checkbox"/> Harm another person - past <input type="checkbox"/> Harm another person - present <p>If attempted to harm self in the past, how many times _____</p> | <p>Recent stresses:</p> <table border="0"> <tr> <td><input type="checkbox"/> Death of someone close</td> <td><input type="checkbox"/> Financial difficulties</td> </tr> <tr> <td><input type="checkbox"/> Relationship began or ended</td> <td><input type="checkbox"/> Change in sleeping habits</td> </tr> <tr> <td><input type="checkbox"/> Major move</td> <td><input type="checkbox"/> Conflict with someone close</td> </tr> <tr> <td><input type="checkbox"/> Employment change</td> <td><input type="checkbox"/> Illness, health concerns</td> </tr> </table> | <input type="checkbox"/> Death of someone close | <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> Relationship began or ended | <input type="checkbox"/> Change in sleeping habits | <input type="checkbox"/> Major move | <input type="checkbox"/> Conflict with someone close | <input type="checkbox"/> Employment change | <input type="checkbox"/> Illness, health concerns |
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| <input type="checkbox"/> Relationship began or ended | <input type="checkbox"/> Change in sleeping habits | | | | | | | | | |
| <input type="checkbox"/> Major move | <input type="checkbox"/> Conflict with someone close | | | | | | | | | |
| <input type="checkbox"/> Employment change | <input type="checkbox"/> Illness, health concerns | | | | | | | | | |

I have difficulty:

| | | | | | |
|-------------------------------------------------|-----------------------------------------------|------------------------------------------|-----------------------------------------|-------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Expressing my emotions | <input type="checkbox"/> Controlling my anger | <input type="checkbox"/> Handling stress | <input type="checkbox"/> Making friends | <input type="checkbox"/> Accepting myself | <input type="checkbox"/> Functioning at work/school |
|-------------------------------------------------|-----------------------------------------------|------------------------------------------|-----------------------------------------|-------------------------------------------|-----------------------------------------------------|

Family members/others who are important to you: Relation/Age _____

My family and I are:

| |
|---------------------------------------------------------------|
| <input type="checkbox"/> In a satisfactory relationship |
| <input type="checkbox"/> Unable to talk about personal issues |
| <input type="checkbox"/> Not emotionally close |
| <input type="checkbox"/> In an unsatisfactory relationship |

| Family History | Family member involved | Please circle all hours you are available for counseling appointments. | | | | | | | | | | |
|-------------------------------------------|------------------------|------------------------------------------------------------------------|---|----|----|----|---|---|---|---|---|---|
| <input type="checkbox"/> Anxiety | _____ | Monday | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 |
| <input type="checkbox"/> Depression | _____ | Tuesday | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 |
| <input type="checkbox"/> Alcohol abuse | _____ | Wednesday | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 |
| <input type="checkbox"/> Drug abuse | _____ | Thursday | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 |
| <input type="checkbox"/> Gambling problem | _____ | Friday | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 |
| <input type="checkbox"/> Eating Disorder | _____ | | | | | | | | | | | |
| <input type="checkbox"/> Suicide | _____ | | | | | | | | | | | |
| <input type="checkbox"/> Self-harm | _____ | | | | | | | | | | | |
| <input type="checkbox"/> Abuse | _____ | | | | | | | | | | | |
| <input type="checkbox"/> Other | _____ | | | | | | | | | | | |